RULE

Department of Health and Hospitals
Office of the Secretary
Bureau of Community Supports and Services

Home and Community Based Services Waiver Program
Standards of Participation
(LAC 50:XXI.Chapter 1)

The Department of Health and Hospitals, Office of the Secretary, Bureau of Community Supports and Services promulgates the following Rule under the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act. This Rule is promulgated in accordance with the Administrative Procedure Act, R.S. 49:950 et seq.

Title 50
PUBLIC HEALTHC MEDICAL ASSISTANCE
Part XXI. Home and Community Services Waivers
Subpart 1. General Provisions
Chapter 1. Standards for Participation
§101. Provider Requirements

A. In order to be reimbursed by the Louisiana Medicaid Program, a service provider agency must comply with all of the requirements of this Part XXI.

B. General Provisions

1. For the purposes of this Part XXI, providers enrolled with the Department of Health and Hospitals (DHH) as a Home and Community-Based Waiver (HCBW) service provider on the effective date of this rule shall have two years to comply with these standards, including attending the Bureau of Community Supports and Services (BCSS) provider orientation for HCBW prior to requesting a provider enrollment visit by the Bureau of Community Supports and Services (BCSS).

2. If a provider is not accessible in their DHH geographical region, individuals and/or families may seek a provider outside of the DHH region with prior approval of BCSS. This approval must be documented in the individual's approved comprehensive plan of care (CPOC) and Freedom of Choice Form (FOC).

3. Providers are responsible for submitting written notification by certified mail to BCSS and Medicaid of any changes in address and/or telephone numbers within 10 days of the change.

4. In addition to agency internal employer reporting requirements, any employee or consultant/contractor of the enrolled provider who witnesses, learns of, is informed of, or otherwise has reason to suspect that an incident of abuse, neglect, or exploitation has occurred must report such incident in accordance with BCSS critical incident reporting, child and/or adult protection laws, and fully cooperate with the investigation of the incident.

C. Physical Facilities and Equipment

1. The provider shall maintain an office site in each region of operation.

a. Each site must house the case records and billing information for all individuals served by that office.

b. Each regional site must maintain a toll-free telephone line with 24-hour accessibility and manned by an answering service. The toll-free number must be given to individuals at intake or at the first meeting.

c. The provider must have daytime office hours that conform to the usual and customary operating hours of the local business community.

d. The provider must maintain a current brochure that outlines provider services, address and telephone numbers for distribution to the public.

2. The provider must obtain and maintain computer equipment, internet accessibility, and software as specified below:

a. IBM-compatible PC with a Pentium Processor 4 or later version, and/or capable of using specific software required by BCSS:

b. 1.44 MB 3.5 inch disk drive;

c. 32 MB of RAM or more;

d. 25 MB free hard drive space or more;

e. color monitor;

f. printer;

g. modem (28.2k or faster);

h. CD-ROM;

i. Windows 95 operating system or later version;

j. internet account with e-mail and web-browser software.

D. Provider Training

1. New providers shall attend the BCSS provider orientation for HCBW providers and meet all required standards prior to being enrolled as a waiver service provider. BCSS provider orientation will be held in January and June.

2. All enrolled providers will be required to attend an annual BCSS training conducted to continue enrollment. Additional training may be required by BCSS if deemed necessary.

3. Those employees having direct contact with recipients must obtain no less than 16 hours of basic orientation in addition to any individualized, specialized training needed to work with a recipient on a daily basis prior to becoming solely responsible for implementing that recipient's support plan.

4. All provider training shall be competency-based (results driven).

5. Training shall include, but is not limited to, the following:

a. abuse/neglect/incident reporting;

b. staff ethic, including the strict prohibition against soliciting consumers from other provider agencies, respectful interactions with people being supported, and the use of People First Language;

c. confidentiality, privacy rights, and HIPAA;

d. human and civil rights;

e. person centered planning;

f. personal outcomes;

g. consumer direction/self determination philosophy;

h. infection control/universal precautions, first aid and emergency procedures;

i. environmental emergency procedures;

j. provider policies and procedures;

k. documentation of services, progress notes, service logs, etc.

6. The provider shall have an employee designated as a training coordinator whose responsibilities include, but are not limited to, the following duties:

a. staff training;

b. staff development; and

c. maintenance of training records.

E. Personnel and Human Resources

1. Program or Executive Director

a. The program director or executive director shall meet the following requirements:

i. be a registered nurse (RN) and have one year of verifiable experience in direct service work with persons with disabilities;

ii. have a bachelor's degree in a human services field (such as, but not limited to, hospital or nursing home administration, physical therapy, occupational therapy, speech therapy, social work or psychology) or is currently enrolled in an accredited college and pursuing a bachelor's degree in a human services field. The individual will have a period of three years to complete the course of study; and

iii. have a minimum of one year verifiable work experience, post degree or have one year of experience while working on the degree, in planning and providing direct support to:

(a). persons with mental retardation or other developmental disabilities; or

(b). disabled adults; or

(c). elderly persons with chronic disabling illness; or

b. in the absence of having an employee that meets the qualifications in §101.E.1, the provider must have a contract with a person so qualified to serve as program director to assure that services are delivered as described in the approved CPOC.

2. Direct Support Staff. Direct support personnel/staff shall possess validated direct care abilities, skills and knowledge to adequately provide the care and support required by a recipient receiving waiver support services.

a. Direct support staff shall be at least 18 years old and possess a high school diploma, GED, a trade school diploma in the area of human services, demonstrated competency, or have verifiable work experience in providing support to individuals with disabilities.

3. The provider shall develop and implement policies and procedures for the recruitment, hiring, and retaining of qualified, competent personnel including:

a. obtaining at least three references from previous employers and/or work supervisors;

b. strategies to recruit and employ staff representative of the cultural and ethnic groups supported;

c. conducting criminal background checks on all employees prior to allowing the employee to work directly with individuals receiving HCBW services;

d. strategies for retaining competent staff and staff development;

e. compliance with Fair Labor and Child Labor laws;

f. agency backup plans for staff coverage when direct care staff fail to report for duty as scheduled. The plan must include strategies to assure that backup direct support staff have been trained in the individualized, specialized care and support needed;

g. protocol outlining how the agency will have staff available during emergencies or unexpected changes in the recipient's schedule;

h. a staff evaluation process that addresses the quality of the staff's support to individuals served and includes consumer satisfaction information from the recipient/guardian or authorized representative;

i. policies outlining the chain of command and supervisory roles including:

i. protocol for staff supervision;

ii. protocol for investigation and resolution of complaints regarding the staff's performance.

4. The provider must have an approved Quality Assurance/Quality Improvement (QA/QI) plan. The QA/QI plan shall include the following:

a. a process for obtaining input from recipient/guardian/authorized representative and family members of those receiving waiver supports;

b. a process for identifying the risk factors that put the recipients at high risk and affect or may affect or may affect health, safety, and/or welfare of individuals being supported;

c. accepted methods for data collection, frequency of collection, source of data, identification of thresholds, analysis of data and identification of trends and patterns in service delivery:

i. the provider shall develop strategies to benchmark service improvement over time;

ii. the QA/QI program outcomes shall be reported to the program director for action as necessary for any identified systemic problems.

5. The QA/QI plan must be submitted to BCSS in accordance with the following time schedule.

a. The QA/QI plan is due 60 days after documented QA/QI training by BCSS and annually thereafter.

b. Self-evaluation of QA/QI plan is due six months after the approval by BCSS of the QA/QI plan.

c. A self evaluation of the QA/QI program is to be submitted annually thereafter to BCSS.

6. The provider shall develop and implement system accountability for billing in keeping with generally accepted accounting principles and provide annual cost reports as requested by BCSS for systems evaluation.

F. License Documentation

1. The provider must adhere to all licensure regulations. The provider shall maintain a current license for all applicable areas of service provision and shall provide BCSS with current documentation of licensing including all deficiencies, corrective action plans and follow-up licensing reviews.

2. Providers not adhering to licensing regulations and/or not attending scheduled re-enrollment will be denied new referrals by Freedom of Choice. If the provider does not comply with these requirements, steps will be taken to disenroll the agency as a Medicaid provider for HCBW.

3. Providers operating under a provisional license or under an extended license due to noncompliance with licensing regulations must demonstrate satisfactory progress toward correction of the deficient practices in order to maintain provider standing for continued enrollment as a waiver service provider. Providers possessing provisional licenses due to noncompliance shall be removed from the Freedom of Choice list until all deficiencies have been corrected and a full license has been obtained.

4. Staff transporting an individual receiving HCBW services shall have a valid (current) driver's license, current liability insurance, and the vehicle shall be in safe operating condition as determined by a current inspection sticker.

G. Fiscal Accountability

1. The new provider (applicant) shall establish a business plan which includes cash flow projections and which has been-reviewed by a fiscal entity (e.g., a CPA) who attests to the adequacy of the plan for meeting the provider's monthly overhead and payroll requirements on an ongoing basis. A notarized letter from the fiscal entity will serve as evidence and shall be available for review upon request by BCSS.

2. Existing providers shall have an established relationship with a fiscal entity (i.e., a bank) to assure fiscal stability and documentation in the form of liquid assets or the ability to secure approval for a line of credit.

3. Requirements for average rates of pay and/or benefit packages for direct support staff will be responsive to the overall funding of the services to the program by the DHH.

H. Records and Documentation

1. The provider shall comply with the Health Insurance Portability and Accountability Act of 1996, (HIPAA) as defined by the Centers for Medicare and Medicaid Services.

2. A complete and separate record for each individual served shall be maintained, including:

a. planning meeting minutes;

b. CPOCs;

c. service logs;

d. billing records;

e. progress notes;

f. eligibility records; and

g. all other pertinent documents.

3. The provider shall provide all case records and billing documents to BCSS as required for monitoring activities and investigations upon request on site or within two hours if records are stored off site.

4. The provider will maintain the following documents and provide them to BCSS upon request:

a. copies of the current approved CPOC, the current service plan and all CPOC revisions in the individual's case record and in the individual's home. (Note: These documents must be current and available);

b. documentation of payroll and services delivered within a time period must agree. Documentation of services delivered within a pay period will be recorded in the individual's home record;

c. updated and implemented service plan to meet the service changes warranted by CPOC revisions within five calendar days of receiving a copy of the approved CPOC revision;

d. a copy of the behavior support plan, if one is required, in the recipient's home.

5. The provider shall maintain documentation to support that services were rendered as per the approved CPOC and service plan. The provider shall:

a. maintain documentation of the day-to-day activities of the recipient (service logs and progress notes);

b. maintain documentation detailing the recipient's progress towards his/her personal outcome;

c. maintain documentation of all interventions used to ensure the recipient's health, safety and welfare. (Note: interventions may include, but are not limited to, medical consultations, environmental and adaptive interventions, etc.)

6. The provider shall develop written policies and procedures relative to the protection of recipient's rights which include, but are not limited to:

a. human dignity/respectful communications;

b. person-centered planning/personal outcomes;

c. community/cultural access;

d. right to personally manage his/her financial affairs, unless legally determined otherwise or he/she gives informed consent;

e. right to refuse service/treatment;

f. civil rights (such as right to vote).

I. Discharges and Transfers

1. The provider's responsibilities for voluntary planned transfers or discharges from their agency shall include:

a. obtaining of a written request for transfer to another agency and the expected transfer date/time from the individual or his/her authorized representative;

b. notifying the recipient's case manager within 24 hours for planning to begin;

c. allowing the case manager no less than two weeks (14 calendar days) and up to 30 days (if needed) for planning the transfer, unless it is for an emergency placement;

d. participating in the planning meeting facilitated by the case manager who assures the availability of appropriate services through the receiving agency; and

e. with the written consent from the recipient, both the transferring and the receiving agencies shall share responsibilities for ensuring the exchange of medical and program information which shall include:

i. current CPOC;

ii. current service plan;

iii. a summary of behavioral, social, health and nutritional status; and

iv. any other pertinent information.

2. The provider must have written policies and procedures for the management of involuntary discharges/transfers from their agency.

a. Involuntary transfers/discharges from their services may occur for the following reasons:

i. medical protection of the well being of the individual or others;

ii. emergency situations (i.e., fire or weather related damage); or

iii. any direct threat to the recipient's health, safety and/or welfare.

b. Involuntary transfers/discharges may occur when a provider identifies an inability to provide the services indicated in the recipient's CPOC, but only after documented reasonable accommodations have been tried and have failed.

c. Provider responsibilities include submission of a written report to the BCSS regional office, detailing the circumstances leading up to the decision for an involuntary transfer/discharge and provision of the documentation of the provider's efforts to resolve issues encountered in the provision of services.

d. All team conferences shall reflect a person-centered process and be conducted with the recipient, guardian or authorized representative, case manager and the appropriate provider personnel to develop or update the CPOC.

e. The recipient, guardian or authorized representative will be notified in writing at least 15 calendar days prior to the transfer or discharge fom the provider agency. The individual's rights shall be assured throughout the process. The written notification shall include:

i. the proposed date of transfer/discharge;

ii. the reason for the action; and

iii. the names of personnel available to assist the individual throughout the process.

f. The service provider shall provide the recipient, guardian, or authorized representative with information on how to request an appeal of the decision for involuntary discharge.

i. The recipient may request reconsideration through the service provider's grievance policy and procedures.

ii. The recipient may request an informal reconsideration hearing with BCSS and the discharging service provider.

iii. If the recipient is not satisfied with the results of the informal reconsideration hearing, an appeal may be filed with the DHH Appeals Section by notifying the regional BCSS office or the DHH Bureau of Appeal.

J. Emergency Situations

1. Immediate jeopardy situations shall be handled immediately and the recipient's guardian or authorized representative, BCSS regional office, and the case manager must be notified immediately, no later than 48 hours after the provider's direct support staff and/or the provider's administrative staff learns of the immediate jeopardy situation.

a. The notification shall include:

i. the anticipated action;

ii. that the action will take place within 48 hours unless an emergency situation exists; and

iii. the names of personnel available to assist the individual and/or their family through the process.

b. A critical incident report and investigation must begin as soon as possible after the individual is safe.

2. Critical incidents shall be reported to all appropriate law enforcement agencies as directed by state law and as directed in the Bureau's critical incident policy and to BCSS within two hours of the agency's Executive Director or his/her designated representative's first knowledge of the incident. If after business hours, a message shall be left on the BCSS toll-free line voice mail and a critical incident report must be sent via FAX on the next business day.

a. Critical incident updates shall be sent to BCSS within 72 hours and a final report to BCSS up to the 30 days from the incident.

b. The waiver service provider's responsibilities for critical incident reporting are:

i. immediately assuring the recipient's health and safety;

ii. reporting the incident to BCSS and the case manager;

iii. conducting an internal investigation;

iv. cooperating with all critical incident investigations;

v. resolution of all critical incidents and complaints against the provider; and

vi. implementing a plan of correction for problems identified in the course of critical incident investigations.

K. Recipient Provisions and Rights

1. The center-based respite provider may serve recipients residing in other regions other than the region in which it is located. The selection should be approved by BCSS and included in the recipient's CPOC.

2. An individual is linked to a provider for a period of six months at a time.

a. The recipient may not transfer to a different provider until after the six-month period without "Good Cause."

b. The provider shall not refuse to serve any individual who chooses their agency, unless there is documentation to support an inability to meet the individual's health, safety and welfare needs, or all previous efforts to provide services and supports have failed and there is no option but to refuse services. The BCSS must be notified of the circumstances.

c. Requirements in Paragraph 2.a-b above can only be waived by BCSS.

3. The BCSS toll-free help line number must be included in the contact packets left in the recipient's home.

4. The provider shall encourage and support the recipient in the development of the CPOC and provider service plan by:

a. obtaining the recipient's personal choices, vision, and preferences and incorporating them into the individual's person-centered CPOC;

b. assessing the recipient's:

i. skills;

ii. needed supports; and

iii. health, safety and welfare needs.

c. development of strategies to meet the recipient's service needs and timely development of the service plan to implement the strategies; and

d. the development of a process to monitor the ongoing implementation of the plan.

L. Case Management. The provider shall have a written working agreement with the case management agency serving the recipient. The agreement shall include:

1. written notification of the time frames for CPOC planning meetings;

2. the timely notification of the meeting dates and time to allow for provider participation;

3. how agencies will exchange information, such as notification of changes in the CPOC or in service delivery; and

4. assurance that the provider sends the appropriate provider representative to the planning meetings as invited by the recipient.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Community Supports and Services, LR 29:1829 (September 2003).

§103. Agency Responsibilities

A. Both federal and state laws and regulations authorize the Department of Health and Hospitals to maintain the programmatic and fiscal integrity of the Medicaid Home and Community-Based Services Waiver Program. The Bureau of Community Supports and Services is charged with the responsibility to set the standards, monitor the outcomes and apply administrative sanctions for failures by service providers to meet the minimum standards for participation. All failures to meet minimum standards shall result in a range of required corrective actions including, but not limited to, removal from the Freedom of Choice listing, a citation of deficient practice, a request for a corrective action plan and/or administrative sanctions. Continued failure to meet minimum standards shall result in loss of referral of new HCBW recipients and/or continued enrollment as a home and community-based waiver service provider.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

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